SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in place and would like to comment why, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program		Separate Child Health Program	
Eligibility	From ____ % of FPL for **infants** ____ % of FPL		From 140 % of FPL for **infants** 200 % of FPL	
	From ____ % of FPL for children ages **1 through 5** ____ % of FPL		From 133 % of FPL for children ages **1 through 5** 200 % of FPL	
	From ____ % of FPL for children ages **6 through 16** ____ % of FPL		From 100 % of FPL for children ages **6 through 16** 200 % of FPL	
	From ____ % of FPL for children ages **17 and 18** ____ % of FPL		From 100 % of FPL for children ages **17 and 18** 200 % of FPL	
Is presumptive eligibility provided for children?	____ No		**X** No	
	____ Yes, for whom and how long?		____ Yes, for whom and how long?	
Is retroactive eligibility available?	____ No		**X** No	
	____ Yes, for whom and how long?		____ Yes, for whom and how long?	
Does your State Plan contain authority to implement a waiting list?	Not applicable		**X** No.	
			____ Yes	
Does your program have a mail-in application?	____ No		____ No	
	____ Yes		**X** Yes	
Does your program have an application on your website that can be printed, completed and mailed in?	____ No		____ No	
	____ Yes		**X** Yes	
Can an applicant apply for your program over phone?	____ No		____ No	
	____ Yes		**X** Yes	
Can an applicant apply for your program on-line?	____ No		____ No	
	Yes – please check all that apply		**X** Yes – please check all that apply	
	____ Signature page must be printed and mailed in ____ Family documentation must be mailed (i.e., income documentation) ____ Electronic signature is required		**This is only a pilot in limited offices.** ____ Signature page must be printed and mailed in ____ Family documentation must be mailed (i.e., income documentation) **X** Electronic signature is required **(A fax of the signature page is also allowed.)** ____ No Signature is required	
Does your program require a face-to-face interview during initial application	____ No		**X** No	
	____ Yes		____ Yes	

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?		No		No
		Yes Note: this option requires an 1115 waiver Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6	**X**	Yes Note: Exceptions to waiting period are listed in Section III, subsection Substitution, question 6
	Specify number of months		Specify number of months	3
Does your program provide a period of continuous coverage <u>regardless of income changes?</u>		No		No
		Yes	**X**	Yes
	Specify number of months		Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
			The 12 month enrollment guarantee stops if the child: 1. Attains age 19 2. Is no longer a resident of Arizona 3. Is an inmate of a public institution 4. Was ineligible at the time of approval 5. Obtains private or group health coverage 6. Is adopted and the new household does not meet the eligibility criterion 7. Is an inpatient in an institution for mental diseases 8. Whereabouts that are unknown. Or 9. Has a head of household who: a. Does not pay the premium when one is required b. Voluntarily withdraws from the program c. Fails to cooperate in meeting the requirements of the program.	
Does your program require premiums or an enrollment fee?		No		No
		Yes	X	Yes
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below	
			1 child enrolled Income >150% but ≤175% FPL $10 Income >175% but ≤200% FPL $15 2 or more children enrolled Income >150% but ≤175% FPL $15 Income >175% but ≤200% FPL $20 The combination of cost sharing (co-pays) and premiums shall not exceed 5% of the household's gross income.	
Does your program impose co-payments or co-insurance?		No		No
		Yes	**X**	Yes ($5.00 for Non-emergency use of the emergency room)
Does your program require an assets test?		No	**X**	No
		Yes		Yes
	If Yes, please describe below		If Yes, please describe below	

Is a preprinted renewal form sent prior to eligibility expiring?	[ ] No Yes, we send out form to family with their information precompleted and [ ] ask for confirmation [ ] do not require a response unless income or other circumstances have changed	[X] No Yes, we send out form to family with their information precompleted and [ ] ask for confirmation [ ] do not require a response unless income or other circumstances have changed

2. Are the income disregards the same for your Medicaid and SCHIP Programs? [ ] Yes [X] No

3. Is a joint application used for your Medicaid, Medicaid Expansion and SCHIP Programs? [X] Yes [ ] No

4. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program			**Separate Child Health Program**	
	Yes	No Change		Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)					X
b) Application				X	
c) Benefit structure					X
d) Cost sharing structure or collection process				X	
e) Crowd out policies				X	
f) Delivery system					X
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)				X	
h) Eligibility levels / target population					X
i) Eligibility redetermination process					X
j) Enrollment process for health plan selection					X
k) Family coverage					X
l) Outreach				X	
m) Premium assistance					X
n) Waiver populations (funded under title XXI)				X	

	Parents					**X**	
	Pregnant women						**X**
	Childless adults					**X**	
Other – please specify							
a.	**Disenrollment Survey**					**X**	
b.	**Office Changes**					**X**	
c.	**Quality Case Read Process Changes**					**X**	
d.	**The AHCCCS Medical Policy Manual (AMPM), Chapter 400, was revised during the reporting period.**					**X**	
e.	**Standards by which AHCCCS measures individual contractor compliance with providing medical services and monitors overall program performance were revised during the reporting period.**					**X**	

5. For each topic you responded yes to above, please explain the change and why the change was made, below.

a) Applicant and enrollee protections **(e.g., changed from the Medicaid Fair Hearing Process to State Law)**	N/C
b) Application	In October of 2001, the implementation of the Application for AHCCCS Health Insurance (formerly known as the Universal Application) form began. This application is used to determine eligibility for any of the AHCCCS medical programs, including Medicaid and SCHIP. It is also accepted by both of the agencies in Arizona who determine eligibility for medical assistance programs. AHCCCS staff determines eligibility for SCHIP, Long Term Care and the Medicare cost sharing programs. The Department of Economic Security (DES) staff determines eligibility for most other Medicaid programs. Prior to this, each program had it's own application. If a household contained members who were eligible for several different programs, they would need to fill out a separate application for each program and possibly bring them to different agencies. This new application increases the efficiency and effectiveness of the application process for all programs and makes it easier for the client to be screened for all programs. The new application also has a companion flyer that is designed to accompany it. The companion flyer explains the different programs, covered services, and how to apply. The instructions on the new application direct individuals applying for children to send their applications directly to KidsCare and those applying for adults only to send their applications to the Central Screening Unit (CSU). The CSU screens the applications to determine which program each applicant is potentially eligible for and then forwards them to the appropriate agencies to be processed. In FFY 2002 CSU has screened and referred 12,446 applications. Of those 7,284 have been sent to the Department of Economic Security (DES) for a Medicaid determination, 4,480 to Premium Sharing (a state funded program), 959 to KidsCare, 2763 to SSI/MAO and 40 to Arizona Long Term Care System. AHCCCS, in partnership with the Department of Economic Security and the Community Health Centers Collaborative Venture, has developed a fully automated web based electronic application called Health-e-Arizona. This application was piloted beginning June 17, 2002 by El Rio Health Center in Tucson. The project is going well and will soon be rolled out to other sites in Arizona. From June 17, 2002 to September 30, 2002 this system has routed 1488 applicants for application processing for medical services. The application has been programmed to screen for potential eligibility in our AHCCCS programs and refers each applicant either to DES, KidsCare or CSU. AHCCCS plans to have this project rolled out to all Federally Qualified Health Centers in FFY 2003.
c) Benefit structure	N/C

d) Cost sharing structure or collection process	As a result of legislation, a family may avoid termination of coverage resulting from non-payment of premium by showing the existence of a hardship. Hardship is defined as medical expenses, health insurance premiums, repairs to the home or to vehicles used to get to work which cumulatively exceed ten percent of the family's gross household income. The death of a family member is also considered a hardship. In FFY 2002, AHCCCS has received 993 requests for hardship waivers, of those, 61 have been approved. Many of the requests did not contain allowable expenses. Because of this, AHCCCS is revising the hardship request form so those clients will be able to better understand which expenses are allowable.
e) Crowd out policies	Effective for eligibility beginning October 1, 2001, Arizona Statute reduced the mandatory waiting period following voluntary termination of other creditable health insurance coverage from six months to three months. Because a child may be approved up to three months prospectively if all eligibility requirements are met, except for the waiting period, a major impact is that applications are no longer denied due to the waiting period. The waiting period is waived entirely for a seriously or chronically ill child. In FFY 2002, AHCCCS has waived the waiting period for 48 children who were seriously or chronically ill.
f) Delivery system	N/C
g) Eligibility determination process **(Including implementing a waiting lists or open enrollment periods)**	In May of 2002, KidsCare began a pilot to transition children who applied for Medicaid and have been denied for excess income. A computer interface process sends the children's records to the KidsCare eligibility computer system and screens them for potential KidsCare eligibility. This process produces a report that contains enough information to identify the child in the DES computer system enabling AHCCCS to use the information to make the Medicaid decision. KidsCare staff then sends a one-page form to the parents asking for the additional information needed for SCHIP. When the completed forms are received, the KidsCare staff determines eligibility for the program. From May 2002 through September 2002, over 1500 children were approved for KidsCare using this process. Previously, AHCCCS piloted a similar project where we mailed an application to the parents of children who were denied Medicaid for excess income. At that time AHCCCS found that the parents did not follow through with the application process. This simplified process has worked well.
h) Eligibility levels / target population	N/C
i) Eligibility redetermination process	N/C
j) Enrollment process for health plan selection	N/C
k) Family coverage	N/C
l) Outreach	During this last fiscal year, AHCCCS concentrated on collaboration efforts. The AHCCCS Community Relations Administrator (CRA) developed a network consisting of community based and other state/county/municipal agencies to assist her in conducting outreach/education activities to maximize the effort. The CRA has also arranged for training of many community based organizations and other groups on KidsCare and the AHCCCS application for Health Insurance (includes KidsCare Program) so that they can, in turn, provide assistance to their clients and communities.
m) Premium assistance	N/C

n) Waiver populations (funded under title XXI)	
Parents	Arizona received approval for a HIFA waiver in December 2001. This waiver includes the use of Title XXI funds for certain parents of children enrolled in the Arizona Medicaid or SCHIP programs. AHCCCS plans to implement this portion of the waiver effective January 2003. Results of the change will be submitted in the FFY 2003 report.
Pregnant women	N/C
Childless adults	As previously stated, Arizona has received approval for our HIFA waiver. This waiver also includes the use of Title XXI funds for certain single adults and childless couples with adjusted net family income of more than 40 percent and below 100 percent of the Federal Poverty Level. This portion of the waiver was implemented November 1, 2001.
o) Other – please specify	
a. Disenrollment Survey	In February 2002, AHCCCS began sending out a survey to parents whose children were disenrolled for preventable reasons. From February to August 2002, 300 surveys per month were mailed out. In September 2002, AHCCCS began sending out 500 surveys per month. Of the 2600 surveys sent out from February through September 2002, 378 have been returned. AHCCCS has collected some valuable information in terms of needing to further educate the parents of our members and discovering that many families self-screen themselves out of the program. AHCCCS plans to use this information to make further improvements in an attempt to retain our children.
b. Office Changes	The **office manager's functions** have been divided into primarily two functions, intake and specialty. One office manager primarily oversees all intake units. The other office manager oversees two specialty units, two renewal units and one unit that performs intake, renewal or specialty functions as needed. This has enabled the staff that work on these functions to be in the same work area, and has reduced the time involved to assign and monitor the work. **Phone prompt system -** The phone script was revised to offer the client the option to leave information about changes, instead of the staff having to call back on each change reported. **Medicaid referrals -** Beginning, September 3, 2002 a new process was implemented. If information needs to be requested for a KidsCare determination, the KidsCare worker will request what is needed for DES. If there is no need to request information for KidsCare then the KidsCare worker will complete the KidsCare determination and refer the application to DES. DES will then request what they need to complete the Medicaid determination. This new process has worked very well for both agencies and the clients are responding appropriately to both agencies.

c. Quality Case read Process Changes	In March of 2002, KidsCare dedicated two employees to the Quality Assurance case read process. Prior to this it was the responsibility of each Unit Supervisor to conduct Quality Assurance case reads. The two dedicated employees bring uniformity and equity to the office reviews, identify error trends and training needs, and give the workers useful feedback. The process above allowed the Unit Supervisors time to work with their staff in the areas that were most error prone. Beginning April 1, 2002, a quality initiative process was implemented to target the insurance and income areas of the cases that their staff dispositioned. To date they have completed 2,955 of these targeted case reads.
d. The AHCCCS Medical Policy Manual (AMPM), Chapter 400.	The AHCCCS Medical Policy Manual (AMPM), Chapter 400, was revised during the reporting period to ensure that AHCCCS contractors and fee-for-service providers have complete and up-to-date information regarding requirements for providing services to children enrolled through KidsCare
e. Standards by which AHCCCS measures individual contractor compliance with providing medical services and monitors overall program performance were revised during the reporting period.	Standards by which AHCCCS measures individual contractor compliance with providing medical services and monitors overall program performance were revised. AHCCCS established Minimum Performance Standards, Goals and Benchmarks for indicators of clinical/preventive health care services. These revisions are designed to encourage contractors to improve their performance indicator levels from year to year and make strides toward Benchmarks, which are based on Healthy People 2000 and Healthy People 2010 objectives.